IPA Growth Model

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Overview

IPAs represent a coalition of providers and financers of health care coming together to provide integrated health care services to managed populations. These might be employer groups, people enrolled in Medicare Advantage and other government-sponsored programs, or other health plan members. To remain successful in an increasingly competitive health care environment, IPAs must provide value to each of these key constituencies, while remaining compliant with diverse regulatory requirements.

Figure One: IPA End Users and Funds Flows

Employer
$
$
Government
Health Plan / TPA
Commercial Covered Lives
$
Government-Sponsored Covered Lives
$
IPA
$
$
$
$
Hospital
Member Physicians
Referral and Ancillary Providers
Pharmacy

Strategic Focus

To remain successful in an evolving health care environment, IPAs must maintain a relentless focus on providing value to all of the “end users” of their services—their members (physicians), their clients (payers), and the people they collectively serve (covered lives)—while also being mindful of their overseers (regulatory agencies).

- Contracting Payers: IPAs must demonstrate value to their contracting health plans, thereby attracting potential new Payor partnerships and increasing geographic dominance while simultaneously increasing switching costs for new and existing Payor partners (e.g., through connectivity and enhanced outcomes). This requires demonstrating cost-effective clinical care with respect to directly and indirectly controlled physician, hospital, pharmacy, and ancillary services. In addition to demonstrating cost controls, this entails documenting superior quality of care measures (e.g., HEDIS, PQRI). It is important also for IPAs to enable health plans to maximize Medicare reimbursements through effective HCC coding.

  IPAs achieve sustainable success only if they can develop a degree of integration and coordination that payers cannot reach by themselves through direct contracting. IPAs are typically comprised of large numbers of relatively small practices, each with its own set of systems, structures, and processes, as well as strategies, styles, and skills. The task of the IPA is to integrate these diverse physician practices into a coordinated network that works efficiently and effectively to meet the needs of payers. This requires extraordinary leadership, but increasingly also requires significant investments in systems to manage operations and information, as well as evidence-based clinical and administrative processes to achieve and document superior outcomes. MED3OOO helps our IPA clients achieve "virtual" integration of their member physician practices through technology solutions (e.g., EDI links to disparate practice management systems and clearinghouses, with data warehousing of information extracted from disparate systems to provide integrated reports) and through operational solutions (e.g., management of provider relations, predictive modeling and population health management services). Technology solutions and operational solutions each build off the other.

- Covered Lives: IPAs seek a net increase in membership in their targeted market segments (e.g., commercial enrollees, government-sponsored enrollees, special needs populations). This is accomplished by offering, either directly by the IPA or indirectly through IPA member physicians, services that will be attractive to covered individuals and create switching costs for those individuals. Such services might be clinical (e.g., personalized population health management), operational (e.g., proactive patient outreach for needed services), or technological (e.g., Personal Health Records) in nature. It's important that the IPA establish these "bonds," not only with patients who are receiving care from IPA member physicians, but also with healthy individuals who have not yet established physician relationships. One way in which MED3OOO can works with our IPA clients to establish relationships with *all* of their covered lives, while also improving clinical outcomes and maximizing pay-for-performance reimbursement, is through our M3/Connect patient recall systems for preventive, screening, and chronic care services.

- Member Physicians: Physicians represent the core constituency of IPAs, since physicians are both the members (and sometimes "owners") of the IPA and the key drivers of IPA clinical operations and ultimate success. The key function of an IPA is to generate above-market reimbursement for member physicians. This may include

negotiated capitation or fee-for-service fees superior to those available to individual physicians in the market. This may also include a variety of additional incentive and bonus payments for documented superior performance: pay-for-performance and PQRI rewards, e-prescribing payments, other incentive payments (e.g., NCQA certification, Medical Home, ARRA "stimulus" payments, and incentives based on the utilization of resources. Above-market reimbursement can also be obtained by ensuring that services are coded and reported accurately (e.g., maximizing revenues available under risk-adjusted payment mechanisms, such as Medicare payments based on Hierarchical Condition Categories).

IPAs can create additional switching costs for member physicians by adding value to physician practices outside the confines of IPA operations. In many cases, the IPA will represent only a minority of practice revenues, so it's important that any requirements that the IPA imposes on a member physician practice not disrupt the operations of that practice for non-IPA patients. It is, in fact, to the IPA's advantage to offer services that enhance non-IPA practice operations and that benefit both capitated and fee-for-service environments. Such practice enhancements might be clinical (e.g., population health management), operational (e.g., RCM solutions for capitated and fee-for-service programs), or technological (e.g., EHR systems, PM systems, patient communications systems) in nature. MED3OOO is well positioned to work with IPAs and other health systems to offer comprehensive or "à la carte" support to physician practices, either on a "brand name" or a "private label" basis.

- Regulatory Agencies: All IPA operations are subject to the regulatory scrutiny of various federal, state, and local agencies. HIPAA privacy and security provisions greatly affect the sharing of information within and between IPA member practices. It's important that IPAs work with technology partners who can help ensure that relevant regulatory requirements are met.

  Additional scrutiny is imposed on IPAs that cannot demonstrate sufficient financial integration (e.g., through the assumption of collective risk or the demonstration of substantial administrative efficiencies) to avoid a *per se* FTC prohibition against illegal collective health plan negotiations. This can be accomplished by demonstrating sufficient clinical integration, which may be aided by any or all of the following: a common EHR platform facilitating the sharing of clinical information, evidence-based medicine and care protocols, population health management programs, patient recalls for preventive and screening services, and care management reporting (including reports for evaluating provider performance).

With respect to each of these end users, the IPA must provide differentiation that provides value to that end user and makes the IPA a uniquely attractive option. An effective IPA strategy must take as its starting point, not just the needs the needs of the IPA itself, but the many—and often conflicting—needs, desires, and styles of each of its constituencies. It is important that strategic initiatives undertaken by IPAs consider each of these critical end users, in order to avoid "improvements" that benefit one constituency at the expense of another.

An IPA can achieve the greatest synergies by focusing on initiatives that create value for all of its end users. For example, IPA subsidization of electronic health records at its member physician practices may achieve some benefits for those practices. However, the IPA can leverage its investment in technology if the subsidized EHR system also facilitates the sharing of information between IPA physicians and with the IPA itself. In this case, the EHR system creates value, not only for the member physician practices, but also for payers (and the IPA itself) since the IPA now gains access to information it can use, along with other available information, for population health management and other clinical purposes. The IPA can further leverage its investment in technology by making a Patient Health Record (PHR) system available to individuals covered through the IPA. In this case, covered individuals (including those who are not currently receiving physician services) are linked into the IPA and see value in IPA services. As discussed later in this paper, MED3OOO is well-positioned to work with our IPA clients to achieve the synergies of a multi-faceted strategy.

In addition to providing value and differentiation to the IPA's end users (individually and collectively), IPA initiatives can achieve maximum impact if they are designed to build off each other as part of a cohesive strategy. IPAs routinely do this as part of building a platform for successful IPA operations, addressing elements such as those outlined in the figure below:

Figure Two: IPA-Focused IPA Strategy Elements

Technology

- Health plan administrative systems to support multiple product lines
- Care management systems

Data

- Claims-based quality reporting (e.g., P4P, HEDIS, PQRI)
- Claims-based operational reporting (e.g., dashboard reports, financial reports)

Operations

- Care management (e.g., utilization/case management, concurrent review and discharge planning)
- Network management (e.g., Payor contracting, provider/customer relations, membership/eligibility tracking, referral/authorization processing, claims adjudication)

Expanding this review to include strategies focused on the end-users of IPA services, rather than the IPA itself, increases the number of options open to the IPA to achieve the broader objectives of the IPA and its key constituencies. These include systems and services provided to IPA member physicians that have direct benefits for those physician practices and indirect benefits to the IPA itself.

Figure Three: End-User Focused IPA Strategy Elements

Technology

- Practice Management (PM) systems
- Electronic Health Record (EHR) systems
- Patient/provider communication systems
- Patient Health Records
- TPA systems

Data

- Multi-source data collection, warehousing, reporting, and predictive modeling
- Decision support systems
- Quality reporting (e.g., P4P, HEDIS, PQRI)
- Operational reporting (e.g., dashboard reports, financial reports)

Operations

- Strategic planning, practice management, site operations
- Revenue cycle management, central operations
- TPA services
- Population health management
- Clinical patient recalls

A comprehensive strategy can provide a roadmap for effective IPA deployment of technology to improve data capture and knowledge-based decision support and thereby enhance outcomes for the IPA and its constituent physician practices. A high-level outline of some of the components of such a strategic roadmap is provided in Appendix One of this document.

A comprehensive strategy can and should include a great many considerations related to group success, including those in the "7-S Framework" adopted by McKinsey and Co.: Strategy, Structure, Systems, Style, Staff, Skills, and Shared Values. In the remainder of this document, we focus on specific issues associated with one of these – systems. In particular, we explore the offering of practice management (PM) and electronic health record (EHR) technologies to IPA member practices.

Technology Overview

When deploying PM/EHR products into an IPA, it is important to consider the overall impact of the implementation upon the consortium of practices. Unlike a typical single practice installation, the IPA model offers opportunities to streamline and standardize processes across practices as well as to gain efficiencies in the implementation through combined training, centralization of services, and a focus upon the development of a common technology infrastructure. MED3OOO is in a unique position to leverage its leadership agreements with IPAs to provide a true service orientation around the implementation of these products vs. the standard "dump and run" approach that is taken by software vendors who are focused on selling licenses with little concern for the ultimate success of the installation.

Technical Considerations

An IPA will most likely prefer an ASP/SaaS deployment model to minimize the complexity of the technical environment at each of the independent practices. The following technical considerations assume this model, regardless of whether MED3OOO or the IPA itself does the hosting.

- Each practice will need appropriate wide area network (WAN) connectivity. This is typically measured in bandwidth (kbps) and latency (ms). Being a browser-based application, network requirements for InteGreat are less demanding, and less costly, than those of a client/server or even a "smart client" (e.g., Java-based) application. Bandwidth for InteGreat PM/EHR should be estimated at 75kbps/concurrent user (bidirectional) with 50ms or less latency. Small practices (10-15 users), which make up the majority of most IPAs, can generally achieve this with a business class DSL connection rated at 1.5MB upload/download at a typical cost of approximately $130/month. T1 lines, as typically required by client/server applications, generally run $600 - $800 per month and are cost-prohibitive for most small practices.
- Each practice will need an Ethernet-based local area network (LAN) to connect workstations and printers to the WAN and to each other. The LAN will use TCP/IP as the primary protocol and will connect into a Cisco router/switch to share the WAN connection among the multiple workstations using network address translation (NAT). Care must be taken when configuring the network across the IPA to ensure that the network addresses do not overlap, thereby making interconnection of offices (discussed later) much more complex. As such, a strategic network plan, as offered by MED3OOO, is required before any practice is brought online.
- Most practices will want a wireless router so that practitioners can move throughout the office while remaining connected to the network. As with the overall network, a wireless plan needs to be developed to ensure appropriate coverage to avoid dead zones as well as to enforce HIPAA-compliant security settings to prevent network intrusion. In an IPA, common wireless protocols and security should be configured to allow centralized management of the wireless environment and to enable users, such as Practice Managers, to move from one location to another without having to reconfigure a wireless connection. Networking requires a specialized skill set that MED3OOO can provide and that becomes all the more important when configuring the network across all practices in the IPA.
- The selection of end-user device is based on personal/practice preference. Some will choose to have workstations in each exam room, while others will prefer laptop and/or tablet computers. Each end-user device must run, at a minimum, MS Internet Explorer and some form of anti-virus software.
- Each practice will require Internet access for ePrescribing and links to external data/educational sources. This access is generally included by the WAN service provider.

- Document scanning will place considerable demands on the WAN (approximately 256kbps per active scanner). If a large volume of scanning will be done at a practice (e.g., when scanning paper charts into the system when first converting from paper to an EHR), the scanning should be done at off-hours. If a practice cannot limit scanning to off-hours, then the scanner should be connected to the hosting facility through a separate WAN connection so that it does not negatively affect the performance of the end-user devices. This will, unfortunately, add to the monthly data communications costs. However, to reduce this cost and to alleviate the initial peak scanning need, the IPA can set up a central scanning location. This not only eliminates the extra bandwidth consumption at the practice, but also reduces the need for temporary staff at each practice to perform back-scanning.
- Interfaces between the various PM and EHR systems within the IPA will require special planning and testing to ensure that data flows properly. These interfaces require staff with the technical capabilities to examine the electronic transactions as well as the functional knowledge of where the data come from/flow to in order to verify complete end-to-end integrity.
- If the IPA provides its own hosting, the following will be required at the hosting facility:
    - Servers running the MS Windows Server 2005 (or better) operating system, IIS, MS SQL Server, and MSF&W scanning; the number and configuration of the servers will be dependent upon the total number of practices/users on the system
    - Network bandwidth to support the total number of users/devices during PEAK periods
    - Network equipments, such as firewalls, routers, switches, etc.
    - Staff that is knowledgeable in both the technical and functional requirements of the applications being hosted
    - Documented disaster recovery and downtime procedures and/or redundant servers at remote locations to ensure continuous operation in the event of a system failure
    - Documented security procedures and routine tests of resistance to network/server intrusion

All of the above are managed by MED3OOO during any implantation and throughout the lifetime of the contract. If MED3OOO is already providing any technology services to the IPA, much of the above will have already been put in place and can, therefore, simply be extended to include additional sites and/or applications.

Operational Considerations

In addition to the technical considerations above, the IPA will need to ensure that the following operational issues are addressed:

- End user/device support – Each practice will need access to technical and functional experts to answer questions about the applications and to troubleshoot connectivity or device issues.
- Practice workflow consultants – As practices convert to a new PM or roll out an EHR, changes in the way practitioners operate will be needed to take advantage of the benefits of the product. The decisions related to this optimal use are best made by a team comprised of individuals who are familiar with the practice in conjunction with specialists who understand the benefits of the products and what has worked/not worked at other practices.
- Clinical content specialist – Because physicians will have variances in how they address and document various medical conditions, templates and clinical content will need to be tailored to match their practice patterns. The IPA may choose to employ a clinical content specialist (generally a nurse or MA) to work with the practices, not only to tailor the content, but also to influence best practices for common medical conditions.
- Financial/billing specialist – Similarly, the IPA may choose to employ a financial specialist to tailor the revenue cycle processes at each practice to optimize eligibility checking, co-pay collection, claim submittal, and remittance posting. Naturally, this is a service that is at the heart of what MED3OOO provides in its Revenue Cycle Management and Manage Care services. More importantly, because most software vendors do not provide these services, they do not consider the impact that the clinical templates within the EHR have on claims and payments. MED3OOO can ensure that the templates match the practice patterns of the clinical staff, but also provide appropriate documentation for maximum reimbursement under fee-for-service plans or minimized cost under capitation.
- Most EHR vendors do not consider the unique requirements of clinical practice in a capitated environment. They deliver canned templates that provide thousands of options in order to cover every clinical possibility and rely on the practitioner to remember the complex rules of the managed care plan. Through close integration with its managed care tools and other data sources, such as predictive modeling and population health management, MED3OOO can make InteGreat EHR, not just a robust clinical documentation tool, but also one that informs the physician of key clinical patterns in order to influence cost-efficient decisions as well.
- Appropriate system sizing and implementation – Because most practices focus on the initial cost of the PM/EHR, vendors will often size the hardware to meet the immediate needs without room for growth. They also tend to minimize the initial estimate for project management, training, and interfaces. Because of this, the IPA can easily find itself in a position wherein the system cannot be fully deployed to all practices due to cost

overruns or lack of system resources that can only be addressed through the costly replacement of relatively new, but undersized, hardware. Because of MED3OOO's experience with these implementations across multiple practices and multiple vendor products, these costly errors can be avoided entirely and the true cost of the system known prior to any implementation.

Beneficial Consolidation

The real value of an IPA cannot be realized without leveraging the operational, financial, and clinical data that are generated at each practice. Consolidating these data into reports that convey a better understanding of what is actually happening across all of the practices will put the IPA in a better bargaining position with payers, suppliers, and regional healthcare providers, such as local hospitals and specialists that are not members of the IPA. This consolidated reporting can be achieved in two ways:

1. For IPAs that employ a homogeneous PM/EHR solution such as InteGreat, consolidated reporting is included with the product and can also be extended through ad-hoc reporting directly against the MS SQL Server databases using the MS SQL Reporting Services toolkit.
2. IPAs that employ a heterogeneous mix of PM/EHR products (by far the majority) can still produce consolidated reports by uploading data into MED3OOO's M3/IQ™ data warehouse. M3/IQ™ stores all data in a common repository, but retains the identification of the data source so that reports can include/exclude data as needed. For example, a report of lab tests ordered for a specific chronic condition (e.g. diabetes) by all family practice/internal medicine physicians across the IPA can be generated for PQRI purposes or for possible contract negotiations with an outside lab.

Using these consolidated reports, the IPA can approach health plans with detailed information to negotiate better contracts and to demonstrate superior outcomes in order to increase their number of covered lives. They can also approach the local hospital with predictive models to negotiate beneficial pricing and services based upon expected admission rates as determined by the IPA's patient population. Fundamentally, having consolidated reporting across all member practices places the IPA in a much stronger position to provide real value beyond simple group purchasing arrangements.

Unfortunately, even though MED3OOO provides consolidation of data from disparate systems, the overall cost of maintaining a heterogeneous mix of systems across the practices within an IPA is higher than that of a homogeneous environment. Specifically, many small practices within an IPA have legacy PM products that were not designed to support data extraction. As such, MED3OOO must develop custom extract/transform/load (ETL) routines for each of these systems. Because of the amount of time required to develop and test the ETL process, it is often more cost-effective to implement a new, state-of-the-art PM product for which ETL routines are either not needed or have already been developed. This is particularly true if an EHR is being deployed at the same time, where the cost of an interface to the legacy PM system compounds the ETL development costs.

Continuity of Care through Systems Integration

All EHR products that are CCHIT 2008 certified must be capable of sending and receiving an HL7 Continuity of Care Document (CCD). This interface transaction contains fundamental information about a patient's clinical condition, including problem history, allergies, meds, lab results, and vital signs. Unfortunately, the HL7 CCD specification does not address how or when a CCD can/should be shared. Therefore, while the core capability of clinical data exchange is present in almost every EHR, most IPAs do not interconnect their EHRs so that they can readily exchange these CCD transactions. As such, practices within the IPA are still dependent upon taking verbal histories from patients, just as they would if the patient came to them from an outside source. MED3OOO has a strategy to employ a combination of the inherent CCD capability within an EHR along with an IPA-sponsored Personal Health Record (PHR) to facilitate the exchange of core clinical data. Essentially, by deploying MED3OOO's technology as embedded in InteGreat or as an add-on to another vendor's EHR, practices that are part of an IPA can save time and eliminate duplicate testing through secure and accurate clinical data sharing. A CCD is uploaded to the PHR at the end of each patient encounter and can be downloaded into the EHR of another practice assuming that the patient has provided consent. As an added benefit, patients can gain access to their own consolidated clinical record through a web-based portal into the PHR and can provide an online or printed view of these data to physicians that have not yet implemented an EHR.

Physician Financial Incentives

The Centers for Medicare and Medicaid Services (CMS) has initiated several incentives to encourage EHR adoption and adherence to best practices. For example, the Physician Quality Reporting Initiative (PQRI) currently provides a 2% reimbursement for the voluntary reporting of specific findings. This reporting focuses on relatively simple measures, such as the percentage of diabetic patients with an HbA1c greater than 9.0%, but is essentially impossible without automation. MED3OOO's InteGreat EHR can produce PQRI reports that are dependent upon clinical values (such as lab results) as a by-product of documenting care, while M3/IQ™ can produce PQRI reports that are based upon claims data, such as the number of women over 65 who have had at least one DXA measurement ordered since turning 65. Because all data within InteGreat EHR and the M3/IQ™ Data Warehouse are stored as discrete elements, they are searchable/reportable with a variety of robust query and reporting products, such as Business Objects and Microsoft Reporting Services. This means that, even if MED3OOO does not currently provide a PQRI or management report that is needed by the practice, it can be quickly developed, either by MED3OOO or the IPA staff, as long as the underlying data have been captured.

These reporting capabilities are vital tools that an IPA can use to negotiate contracts and positively influence per-member-per-month (PMPM) payment rates. Whether it be providing proof of better clinical outcomes or documenting more cost-effective treatment plans, access to detailed data is key to effective negotiations. Armed with this level of information, along with a close understanding of the health care delivery system, the IPA becomes a valued partner with the health plan, rather than having to rely exclusively on the health plan's perspective and priorities. MED3OOO has considerable experience in these negotiations and, with the detailed

data mentioned above, can often put IPAs in a position of strength during what previously had been intimidating discussions with payers.

MED3OOO intends to extend these core capabilities by enhancing the M3/IQ™ Data Warehouse to retain and report upon all elements of the HL7 CCD transaction. By so doing, IPAs will be able to help their members participate in PQRI incentives regardless of the reporting capabilities of their underlying PM/EHR technology. By extending these data to a more robust query and reporting platform, MED3OOO can help the IPA qualify for CMS incentives even when the vendors of their core business and clinical platforms cannot. And, through the development of a patient-centric, web-based portal to the Data Warehouse, MED3OOO will provide physicians and their patients with secure, online access to up-to-date clinical records from anywhere in the world in a future web-based product referred to as the "MED3OOO Healthcare Information Center." Just as the CMS-mandated ePrescribing requirement for access to and review of medication history from all of a patient's prescribers is beginning to prevent harmful medication errors in ambulatory settings, M3/Health InfoCenter will give physicians the ability to review a comprehensive medical history for each patient, regardless of who has historically provided their care, enabling these providers to deliver more cost-effective and safer clinical guidance.

Appendix One: Tech-Knowledgy Roadmap

Commerce (Operations/Systems)		Data Capture & Connectivity		Content Process & Retrospective Reporting		Care Processes & Prospective Reporting	
Production Systems • PM • EHR • Accounting • Payroll • Telephone • Email	**Operational Processes** • Life of a Charge • Prevention • Immunizations • Chronic Disease • Recalls • EDI	**External Data Capture** • Practice Data • Hospital Data • Payer Data • Patient Data • Pharmacy Data • Lab Data • Voice Data • Data Mapping • Data Scrubbing	**Interoperability** • Private Frame • VPN Access • Security • Redundancy • Internet • Intranet • Admin 24x7 • HIPAA • Data Push/Pull	**Business Reporting** • PM (Billing, Demographics, Visits) • Financial (A/P, Cost Accounting) • HR (Payroll, Benefits) • Evidence-Based Management (Capacity, Cost, FTE Matrix, Margins) • Alerts • Key Indicators • Workarounds	**Clinical Reporting** • Workarounds (Institutional, Comorbidity) • Chronic Diseases (Diagnosed, At Risk) • Prevention • Immunization • Specialty • Laboratory • Pharmacy (Refill, Compliance) • Alerts • Key Indicators • Revenue Generation • HEDIS Reporting	**Smart Communications** • One-Way • Two-Way • Scripting • Voice/E-Mail/Fax • Prevention • Diagnosis Follow-Up • Immunization • Reporting	**Population Health Management** • Quality (Preventable Adverse Outcomes) • Care Guidelines (Evidence-Based) • Physician Support (Service Needs, Services not Done, Compliance Data) • Outcomes (Benchmarking, Improvement, Visit History, Disease Control, Rx Compliance, Adverse Outcomes) • Patient Reports • Practice Reports

Functionality

Knowledge